

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

**FILED MAY 10 1944**

**14375**

**1. PLACE OF DEATH**

County..... **Carroll** ..... Registration District No. .... **RR 5-3**  
Township..... **Egypt** ..... Primary Registration District No. .... **4090 5/193**  
City..... (No. ....) ..... St. .... (Ward)

File No. ....  
Registered No. **39**

**2. FULL NAME**..... **Jacob Schreiner**.....

(a) Residence, No. .... **Norborne, Mo. RR. 5** St. .... Ward. ....  
(Usual place of abode) ..... (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred **73** yrs. mos. ds. How long in U. S., if of foreign birth? **73** yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <b>Male</b>	4. COLOR OR RACE <b>White</b>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <b>Single</b>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <b>Single</b>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE	YEARS <b>85</b>	MONTHS <b>10</b>
		DAYS <b>22</b>
		IF LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <b>Farmer</b>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **4 - 9 1944**

22. I HEREBY CERTIFY, That I attended deceased from **April 8**, 19**44**, to **April 9**, 19**44**  
I last saw him alive on **April 9**, 19**44** Death is said to have occurred on the date stated above, at **3:30 a.m.**  
The principal cause of death and related causes of importance were as follows:  
**Chronic myocarditis**  
**Arteriosclerosis**  
**Malnutrition**

Other contributory causes of importance:  
**93d**

Name of operation **None** Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? **no**  
If so, specify .....

(Signed)..... **Joseph H. Haskell** O. M. D.  
(Address)..... **Norborne, Mo.**

12. BIRTHPLACE (CITY OR TOWN)..... **Lorraine**.....  
(STATE OR COUNTRY)..... **France.**

FATHER

13. NAME **John Schreiner.**

14. BIRTHPLACE (CITY OR TOWN)..... **Lorraine.**.....  
(STATE OR COUNTRY)..... **France.**

MOTHER

15. MAIDEN NAME **Josephine Schreiner.**

16. BIRTHPLACE (CITY OR TOWN)..... **Lorraine.**.....  
(STATE OR COUNTRY)..... **France.**

17. INFORMANT..... **Rose Schreiner**.....  
(ADDRESS)..... **Norborne Mo**

18. BURIAL, CREMATION, OR REMOVAL  
PLACE **Sacred Heart Cem** DATE **April 12**, 19**44**

19. UNDERTAKER..... **John Deitch**.....  
(ADDRESS)..... **Norborne Mo**

20. FILED **4 - 11**, 19**44** **John & Deitch Dep.**  
Registrar.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 X7044

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 5-9-44